

Chad Wable Vice President, Marketing & Business Development

August 10, 2005

Cristine A. Vogel, Commissioner Office of Health Care Access 410 Capital Avenue, MS #13HCA P.O. Box 340308 Hartford, CT 06134-0308



RE: CON Determination – Wolcott Health and Wellness Center

Dear Commissioner Vogel,

Enclosed please find an original and five (5) copies of the CON Determination Form for the proposed Wolcott Health and Wellness Center.

We are requesting the project not require a Certificate of Need (CON). This proposal will extend existing physical therapy and sleep services provided by Saint Mary's Hospital to a satellite location in Wolcott. It is intended to reduce the schedule backlog currently experienced at the Waterbury site and improve access to these services for patients residing in Wolcott.

Please feel free to contact me at (203) 709-3368, should you have any questions or require additional information.

Respectfully,

Chad Wable

cc: Bob Anthony, Esq.



State of Connecticut Office of Health Care Access CON Determination Form Form 2020

All persons who are requesting a determination as to whether a CON is required for proposed project must complete this form. Completed forms should be submitted to Commissioner of the Office of Health Care Access, 410 Capitol Avenue, MS#13HCA, P.O. Box 340308, Hartford, Connecticut 06134-0308.

SECTION I. PETITIONER INFORMATION

If more than 2 Petitioners, please attach a separate sheet of paper and provide additional information in the format below:

	Petitioner
Full legal name	Saint Mary's Hospital, Inc.
Doing Business As	Saint Mary's Hospital
Name of Parent Corporation	Saint Mary's Health System
Mailing Address, if Post Office Box, include a street mailing address for Certified Mail	56 Franklin Street Waterbury, CT 06706
Petitioner type (e.g., P for profit and NP for Not for Profit)	NP
Name of Contact person, including title	Chad Wable Vice President, Marketing and Business Development
Contact person's street mailing address	56 Franklin Street Waterbury, CT 06706
Contact person's phone, fax and e-mail address	Phone: (203) 709-3368 Fax: (203) 709-3238 E-mail: cwable@stmh.org

SECTION II. GENERAL PROPOSAL INFORMATION

a.	Proposal/Project Title: <u>Wolcott Health and Wellness Ce</u> nter					
b.	Location of proposal (Town including street address): 533 Wolcott Road, Wolcott 06716					
C.	List all the municipalities th Waterbury, Wolcott, Plymo	is project is intended to serve:				
d.	Estimated starting date for the project: Construction start date October 2005, operations start date, January 2005					
e.	Type of Entity: (Please che apply)	ck $m{E}$ for Existing and $m{P}$ for Proposed	I in all the boxes that			
ΕP		ΕP	ΕP			
	Acute Care Hospital	☐☐ Imaging Center	Cancer Center			
	Behavioral Health Provider Hospital Affiliate	☐☐ Ambulatory Surgery Center☐☐ Other (specify):	Primary Care Clinic			

SECTION III. EXPENDITURE INFORMATION

- a. Estimated Total Capital Expenditure/Cost: \$122,350
- b. Please provide the following breakdown as appropriate: (may not represent the aggregate shown above)

New Construction/Renovations	
Medical Equipment (Purchase)	
Imaging Equipment (Purchase)	
Non-Medical Equipment (Purchase)	\$122,350
Sales Tax	
Delivery & Installation	
Total Capital Expenditure	\$122,350
Fair Market Value of Leased Equipment	
Total Capital Cost	\$122,350

Major Medical and/or imaging equipment acquisition:

Equipment Type			me [Model	Number o	of Units	Cost per unit
Note:	Provid	de copy of contract	with vendor	for medical	equipment		
c.	Туре	of financing or fund	ing source:				
	\boxtimes	Operating Funds		Lease F	inancing		Conventional Loan
		Charitable Contrib	utions 🗌	CHEFA	Financing		Grant Funding
		Funded Depreciati	on 🗌	Other (specify):		

SECTION IV. PROPOSAL DESCRIPTION

Please attach a separate 8.5" X 11" sheet(s) of paper and provide no more than a 2 page description of the proposed project, highlighting all the important aspects of the proposed project. Please be sure to address the following (if applicable):

- 1. Currently what types of services are being provided? If applicable, provide a copy of each Department of Public Health license held by the Petitioner.
- 2. What types of services are being proposed and what DPH licensure categories will be sought, if applicable?
- 3. Will you be charging a facility fee?
- 4. Who is the current population served and who is the target population to be served?
- 5. Who will be providing the service?
- 6. Who are the payers of this service?

Proposal Description:

The purpose of this proposal is to expand Saint Mary's Health and Wellness Center to the Wolcott area, specifically physical therapy and sleep testing. Currently, Saint Mary's Hospital offers outpatient physical therapy and a full-service sleep laboratory at 1312 West Main Street for the patients of the Greater Waterbury area. This facility is running at capacity with the demand for both services increasing. In order to meet the needs in our community, this proposal will extend the existing physical therapy and sleep services provided by Saint Mary's Hospital to the satellite location in Wolcott. The current backlog of sleep study testing is 6 weeks. Currently, 19% of total patients reside in Wolcott. Existing physical therapy services in Wolcott include one privately-owned solo practice, with a reported backlog of patients. The Wolcott area is experiencing population growth, and is projected to grow another 7% over the next five years (reaching a population of over 17,500)¹. Saint Mary's new site in Wolcott will provide better access to the growing number of patients seeking physical therapy and sleep services, and reduce the backlogs currently being experienced.

The Sleep Disorders Laboratory in Wolcott will provide full-service sleep laboratory testing. Diagnostic polysomnography, split-night polysomnography and therapeutic polysomnography services will be offered at night for patients referred to the laboratory. Analysis and interpretation of sleep studies can be performed either on-site or at the parent facility on West Main Street. The Wolcott facility will offer a ground floor entrance for patients' comfort and convenience, with parking immediately adjacent to the front door.

The Wolcott Health and Wellness Center and Sleep Disorders Laboratory will comply with all standards of practice, policies and procedures, and patient care practices at Saint Mary's Hospital. Medical oversight for the Wolcott Sleep Disorders Laboratory will be provided by Dr. Gregory Colodner, who is a state licensed physician and board certified in sleep medicine by the American Board of Sleep Medicine (ABSM).

Trained Polysomnographic Technologists will perform the sleep testing and analysis of all sleep recordings with Medical Director review of each study performed. Technologists comply with department policies and procedures to perform sleep testing and are employees of Saint Mary's Hospital.

Saint Mary's Hospital will bill and collect for all patients seen at the site. Charges to insurance (third party payers) are based on existing contract rates through Saint Mary's Hospital. All insurance contracts that exist at Saint Mary's Hospital will apply.

The target population includes the eastern portion of Waterbury, Wolcott, and Plymouth. Provision of physical therapy and a sleep laboratory in Wolcott will improve patient access to these services, minimize wait times for patients seeking to schedule such services, provide a shorter drive time for these patients and be more convenient to physicians in Wolcott and the surrounding areas.

Form 2020 Revised 7/02

¹ Population data provided by Claritas, Inc.

SECTION V. AFFIDAVIT

Applicant: Saint Mary's Hospital, Inc.
Project Title: Wolcott Health and Wellness Center
I, Robert P. Ritz CEO (Name) (Position – CEO or CFO)
(Name) (Position – CEO of CFO)
of <u>Saint Mary's Hospital, Inc.</u> being duly sworn, depose and state that the
information provided in this CON Determination form is true and accurate to the best of my
knowledge, and that Saint Mary's Hospital, Inc. complies with the appropriate (Facility Name)
and applicable criteria as set forth in the Sections 19a-630, 19a-637, 19a-638, 19a-639, 19a-
486 and/or 4-181 of the Connecticut General Statutes.
8/10/0r
Signature Date
Subscribed and sworn to before me on the 10th day of August, 2005
Januah young
Notary Public/Commissioner of Superior Court
JANICE M. YOUNG
My commission expires Feb. 28, 2000

Form 2020 Revised 7/02



STATE OF CONNECTICUT

OFFICE OF HEALTH CARE ACCESS

CRISTINE A. VOGEL COMMISSIONER

M. Jodi Rell Governor

August 17, 2005

Mr. Chad Wable Vice President, Marketing and Business Development Saint Mary's Hospital, Inc. 56 Franklin Street Waterbury, CT 06706

RE: Certificate of Need Determination; Report Number 05-30571-DTR Saint Mary's Hospital, Inc.

Wolcott Health and Wellness Center

Dear Mr. Wable:

On August 12, 2005, the Office of Health Care Access ("OHCA") received your Certificate of Need ("CON") Determination request concerning the proposal of Saint Mary's Hospital, Inc. ("SMH") to establish a physical therapy and sleep service center at 533 Wolcott Road in Wolcott, at a total capital expenditure of \$122,350.

OHCA has reviewed the information contained in the request and makes the following findings:

- 1. SMH is an acute care hospital located at 56 Franklin Street in Waterbury, Connecticut.
- 2. SMH proposes to establish a physical therapy and sleep service center at 533 Wolcott Road in Wolcott.
- 3. SMH states that the new site in Wolcott will provide better access to the growing number of patients seeking physical therapy and sleep services.
- 4. Section 19a-638 of the Connecticut General Statutes ("C.G.S.") states, in part, that the introduction of any additional function or services requires authorization from OHCA.

Based on the above findings, OHCA has determined that Saint Mary's Hospital's proposal to establish a physical therapy and sleep service center at 533 Wolcott Road, in Wolcott, represents the introduction of an additional function or service, pursuant to Section 19a-638 of the Connecticut General Statutes. Therefore, CON approval is required for SMH to establish a physical therapy and sleep service center in Wolcott.

OHCA considers the submission of information received on August 12, 2005 as the Letter of Intent for this matter; therefore SMH may file a completed CON application with OHCA between October 11, 2005, and December 10, 2005. The CON application is being mailed to your attention separately.

If you have any questions regarding the above, please contact Paolo Fiducia, Associate Health Care Analyst at (860) 418-7035.

Sincerely.

Cristine A. Vogel Commissioner

Copy: Sandra Bauer, Health Processing Technician, DPH, DCBR



STATE OF CONNECTICUT

OFFICE OF HEALTH CARE ACCESS

CRISTINE A. VOGEL COMMISSIONER

August 18, 2005

Chad Wable
Vice President, Marketing and Business Development
Saint Mary's Hospital Corporation
56 Franklin Street
Waterbury, CT 06706

RE:

Certificate of Need Application Forms, Docket Number 05-30571-CON

Saint Mary's Hospital Corporation Wolcott Health and Wellness Center

Dear Mr. Wable:

Enclosed are the application forms, in paper copy and an electronic copy on diskette, for Saint Mary's Hospital Corporation's Certificate of Need ("CON") proposal for the Wolcott Health and Wellness Center with an associated capital expenditure of \$122,350. According to the parameters stated in Section 19a-638 of the Connecticut General Statutes the CON application may be filed between October 11, 2005, and December 10, 2005.

When submitting your CON Application, please paginate and date each page contained in your submission. In addition, please submit one (1) original and five hard copies; as well as a scanned copy of the complete Application, including all attachments, on CD or Diskette. OHCA requests a copy of the submission be in MS Word format and the scanned copy be in Adobe format. Please submit the Financial Attachment and other data as appropriate in MS Excel format.

The analyst assigned to the CON application is Paolo Fiducia. Please feel free to contact him/her at (860) 418-7001, if you have any questions.

Sincerely,

Kimberly Martone

Certificate of Need Supervisor

Kind Matto

Enclosures



State of Connecticut Office of Health Care Access Certificate of Need Application

Please complete all questions. If any question is not relevant to your project, Not Applicable will be an acceptable response. Your Certificate of Need application will be eligible for submission no earlier than October 11, 2005, and may be submitted no later than December 10, 2005. The Analyst assigned to your application is Paolo Fiducia and may be reached at the Office of Health Care Access at (860) 418-7001.

Docket Number:

05-30571-CON

Applicant(s) Name:

Saint Mary's Hospital Corporation

Contact Person:

Chad Wable

Contact Title:

Vice President, Marketing and Business Development

Saint Mary's Hospital Corporation

Contact Address:

56 Franklin Street

Waterbury, CT 06706

Project Location:

Wolcott

Project Name:

Wolcott Health and Wellness Center

Type proposal:

Section 19a-638, C.G.S.

Est. Capital Expenditure:

(Note: Does not include Capitalized Financing Costs)

\$122,350

1. Expansion of Existing or New Service

,	Wh ser	at s vice	ervice will au	s are currently offered at your facility that the proposed expansion or new ugment or replace? Please list.
	Aug	gme	ent:	
	Re	plac	e:	
2.	Sta	ite l	Health	Plan
	No	que	estions	at this time.
3.	Ap	plic	ant's l	₋ong Range Plan
	ls t	his :	applica	tion consistent with your long-range plan?
		Yes	;	☐ No
	lf "N	Vo"	is ched	cked, please provide an explanation.
4.	Cle	ar I	Public	Need
	Α.	Ex are	plain h ea.	ow it was determined there was a need for the proposal in your service
		i)	a) b) c) d)	de the following information: Primary and secondary service area towns If new facility/service, the population to be served, including the number of individuals to receive the proposed service(s). Include demographic Information, as appropriate. Scheduling backlogs in service area Travel distance from proposed site to service area towns Hours of operation of existing/proposed service
		ii) iii)	Provid	by the existing providers of the proposed service in your service area. He the information as outlined in the following table concerning the ag providers' (in the Applicant(s) PSA) current operations:

Description of Service	Provider Name and Location	Hours and Days of Operation	Current Utilization

Saint Mary's Hospital
Application for Docket 05-30571-CON

August 17, 2005 Page 3 of 10

	iv) What will be the effect of your proposal on existing providers (i.e. patient volume, financial stability, quality of care, etc.)?												
		V)) Prov prope	ide the units osed service	s of servi e. Inclu e	ce proje de the d	ected fo derivat	or the fi ion/ca	irst thi Iculat	ee years ion.	of op	eration c	of the
	В.		Will yo	our proposa le an explar	il remedy nation.	any of	the fol	lowing	barrie	rs to acc	ess?	Please	
				Cultural				Trans	portat	ion			
				Geographi	ic			Econo	omic				
				None of th	e above			Other	(Iden	tify)			
		lf y	ou che	ecked other	than No	ne of th	e abov	e, plea	se pro	vide an	explar	nation.	
	C.		Provid propo	de copies of sal:	any of t	ne follov	wing pl	ans, st	udies	or report	s relat	ed to yo	ur
				Epidemiol	ogical stu	dies			Need	ls assess	sment	S	
				Public info	rmation i	eports			Mark	et share	analy	sis	
				Other (Ide	ntify)			_					
			If non-	e of the abo	ve were	perforn	ned or	are ava	ailable	, please	explai	n.	
5.	Qu	ıali	ty Mea	sures									
	A.		If the proposal is for a new technology or procedure, have all appropriate agencies approved the proposed procedure (e.g., FDA etc.)?										
				es 🗌	No	□ No	ot Appl	icable					
			If "No'	', please pro	ovide an	explana	ation.						
			·										

B.	Applic	k off all the Standa cant for the propos t related to the prop	ed service. Pl	Guidelir ease su	nes that will be utilized I bmit the most recent co	by the opy of each
		rican College ardiology] National Con for Quality A		☐ Public Health Cod ce & Federal Corollar	
	☐ Nation of Charton Cent	onal Association ild Bearing ers	American Co of Obstetricia Gynecologist	ıns &	American College of Surgeons	
	Men Serv	ort of the Inter- tal Society Council ices Administration ation Oncology		llege	Substance Abuse of Radiology	and Health
	Other	: Specify				_
C.	Descr check	ribe in detail how the sed off above.	ne Applicant pl	ans to n	neet the each of the gu	idelines
D.	Applio Medic	Submit a list of all key professional and administrative personnel, including the Applicant's Chief Executive Officer (CEO) and Chief Financial Officer (CFO), Medical Director, physicians, nurses, therapists, counselors, etc., related to the proposal and a copy of their Curriculum Vitae.				
	<i>Note:</i> have	For physicians, ple admitting privileges	ease provide a s.	list of h	nospitals where the phy	sicians
E.	Provio facility	de a copy of the mo	ost recent insp	ection r	eports and/or certificate	e for your
		DPH		JCAH	Ю	
		Fire Marshall Rep	oort 🔲		States Health Dept. rts (new out-of-state pr	oviders)
		AAAHC		AAAA	ASF	
		Other:				
	Note:	Above referenced	d acronyms are	e define	d below. ¹	

¹ DPH – Department of Public Health; JCAHO – Joint Commission on Accreditation of Hospitals Organization; AAAHC – Accreditation Association for Ambulatory Health Care, AAAASF – American Association for Accreditation of Ambulatory Surgery Facilities, Inc.

	F.	Provide copies of any Quarterly Action Reports, Consent Decrees or Statemen of Charges against the Hospital, Physicians and any staff related to the proposal, for the past five (5) years.
	G.	Provide a copy of any plan of action which has been formulated to address the above action against the Hospital, Physician(s) working at the Hospital and/or any staff related to the proposal.
	Н.	Provide a copy of the following (as applicable):
		A copy of the related Quality Assurance plan
		Protocols for service (new service only)
		Patient Selection Criteria/Intake form
6.	Impro	ovements to Productivity and Containment of Costs
	In the	past year has your facility undertaken any of the following activities to improve ctivity and contain costs?
		Energy conservation Group purchasing
		Reengineering None of the above
		Application of technology (e.g., computer systems, robotics, telecommunication systems, etc.)
		Other (identify)
7.	Misce	ellaneous
,	A.	Will this proposal result in new (or a change to) your teaching or research responsibilities?
		☐ Yes ☐ No
	lf	you checked "Yes," please provide an explanation.
	B.	Are there any characteristics of your patient/physician mix that makes your proposal unique?
		☐ Yes ☐ No
	11	f you checked "Yes," please provide an explanation.
	C.	Provide the following licensing information:

- i) If you are currently licensed, provide a copy of the State of Connecticut Department of Public Health license currently held.
- ii) The DPH licensure category you are seeking.
- iii) If not applicable, please explain why.

8. Financial Information

A.	Type	of ownership: (Pleas	se chec	ck off all that apply)				
		Corporation (Inc.)		Limited Liability Company (LLC)				
		Partnership		Professional Corporation (PC)				
		Joint Venture		Other (Specify):				
B.	Provid	de the following finar	ncial in	formation:				
	i)	Department of Pu hospital's audited that has filed its r	ublic He I financ nost re	a-644, C.G.S., each hospital licensed by the ealth is required to file with OHCA copies of the sial statements. If the Applicant is a hospital cently completed fiscal year audited financial and may reference that filing for this proposal.				
	ii)	Provide the total this application.	Provide the total current assets balance as of the date of submission of this application.					
	iii)	Provide a copy of financial stateme new service only	nts, inc	ost recently completed internal monthly sluding utilization volume totals to date. (For				
	iv)	Provide the name established for th		nits of service for the new cost center to be osal.				
	v)	Identify the entity	that w	ill be billing for the proposed service				

9. Major Cost Components/Total Capital Expenditure

Submit a final version of all capital expenditures/costs as follows:

Medical Equipment (Purchase)	\$
Major Medical Equipment (Purchase)	
Non-Medical Equipment (Purchase)*	
Land/Building (Purchase)	
Construction/Renovation	
Other (Non-Construction) Specify:	
Total Capital Expenditure	\$
Medical Equipment (Lease (FMV))	\$
Major Medical Equipment (Lease (FMV)	
Non-Medical Equipment (Lease (FMV))*	
Fair Market Value of Space – (Capital Leases Only)	
Total Capital Cost	\$
Capitalized Financing Costs (Informational Purpose Only)	
Total Capital Expenditure with Cap. Fin. Costs	\$

^{*} Provide an itemized list of all non-medical equipment.

10. Construction Information

- A. Provide a description of the proposed new construction/renovation including the related gross square feet of new construction/renovation.
- B. Provide all schematic drawings related to the project that are available, including existing and proposed floor plans.
- C. Explain how the proposed new construction or renovations will affect the delivery of patient care.
- D. Provide the following information regarding the schedule for new construction/ renovation:

Construction Commencement Date	
Construction Completion Date	
DPH Licensure Date	
Commencement of Operations Date	

11. Type of Financing

Applicant's	s equity:				
Source ar	nd amount:				
Operating F Source/En Available F	tity Name	\$_		revenues annovantil commissiones.	
Contribution		\$_			
Funded dep Other	reciation	\$ _ \$ _			
Grant:					
Amount of gr	ant	\$			
Funding insti		Y			
Convention Connecticu Current CHE	ut Health and Education	al Facilit		ority (CHEFA	a) finan
Connectice Current CHE CON Propose Interest rate Monthly payr	ut Health and Education FA debt ed debt financing	al Facilit	s \$ \$	Drity (CHEFA	s) finan
Connecticution Current CHE CON Propose Interest rate	ut Health and Education FA debt ed debt financing nent	al Facilit	\$ \$ \$ \$		Control of the Contro
Connecticut Current CHE CON Propose Interest rate Monthly payr Term Debt service Lease fina	ut Health and Education FA debt ed debt financing nent reserve fund	al Facilit	\$	%	Control of the Contro
Connecticut Current CHE CON Propose Interest rate Monthly payr Term Debt service Lease fina CHEFA E	ut Health and Education FA debt ed debt financing nent reserve fund	al Facilit	\$ \$ \$ \$	%	Control of the Contro
Connecticular Current CHE CON Propose Interest rate Monthly payr Term Debt service Lease finate CHEFA E CURRENT CHEFA E	ut Health and Education FA debt ed debt financing nent reserve fund ancing or asy Lease Financing: HEFA Leases osed lease financing		\$ \$ \$	%	Control of the Contro
Connecticular Current CHE CON Propose Interest rate Monthly payr Term Debt service Lease finate CHEFA E CUrrent CH CON Prop Fair market lease ince	art Health and Education FA debt ed debt financing ment reserve fund ancing or asy Lease Financing: HEFA Leases osed lease financing et value of leased assets ption		\$ \$ \$ \$	%	Control of the Contro
Connecticular Current CHE CON Propose Interest rate Monthly payr Term Debt service Lease finate CHEFA E Current CHEFA E CON Prop Fair market	at Health and Education FA debt ed debt financing nent reserve fund ancing or asy Lease Financing: HEFA Leases osed lease financing et value of leased assets ption te		\$ \$ \$ \$	%	Control of the Contro

Other financing alternatives:	
Amount	\$
Source (e.g., donated assets, etc.)	

- B. Please provide copies of the following, if applicable:
 - i. Letter of interest from the lending institution,
 - ii. Letter of interest from CHEFA,
 - iii. Amortization schedule (if not level amortization payments),
 - iv. Lease agreement.

12. Revenue, Expense and Volume Projections

A.1. Payer Mix Projection

Please provide both the current payer mix and the projected payer mix with the CON proposal for the Total Facility based on Net Patient Revenue in the following reporting format:

Total Facility	Current	Year 1	Year 2	Year 3
Description	Payer Mix	Projected Payer Mix	Projected Payer Mix	Projected Payer Mix
Medicare*	%	%	%	%
Medicaid* (includes other medical assistance)			1	
CHAMPUS and TriCare				
Total Government Payers				
Commercial Insurers*				
Uninsured				
Workers Compensation				
Total Non-Government Payers				
Total Payer Mix	100.0%	100.0%	100.0%	100.0%

^{*}Includes managed care activity.

A.2.	Please describe the impact of the proposal on the interests of consumers of
	health care services and the payers of such services.

B.	Does the Applicant(s) have Tax Exempt Status?	□ Yes	· □ No
	beed the Applicant(e) have tax Exchipt Status;	1 1 62	IIIO

- C. Provide the following for the financial and statistical projections:
 - i) A summary of revenue, expense and volume statistics, without the CON project, incremental to the CON project, and with the CON project. **See attached.** Please note that the actual results for the fiscal year reported in the first column must agree with the Applicant's audited financial statements.
 - ii) The assumptions utilized in developing the projections (e.g., FTE's by position, volume statistics, other expenses, revenue and expense % increases, project commencement of operation date, etc.).
 - iii) An explanation for any projected incremental losses from operations contained in the financial projections that result from the implementation and operation of the CON proposal.
 - iv) Provide a copy of the rate schedule for the proposed service.
 - v) Describe how this proposal is cost effective.

HOSPITAL AFFIDAVIT

Appli	cant:				
Proje	ct Title:				
Ι,	(Name)		Position -	– CEO or CFO)	
is acc	curate and cor	e) information submirect to the best of mais CON application,	tted in this Ce ny knowledge.	vorn, depose and state tha rtificate of Need applicatio With respect to the finand in that:	n
1.	The proposa	al will have a capital	expenditure in	n excess of \$15,000,000.	
	☐ Yes	☐ No			
2.	operation wi	II exceed one perce the most recently co	nt of the actua	I's first three years of al operating expenses of th I year as filed with the Offi	ie ce
Signa	ature		·	Date	
Subs	cribed and sw	orn to before me on		<u>.</u>	
 Notai	ry Public/Com	missioner of Superio	or Court		
Му с	ommission ex	pires:		_	

13. B(i)...... Please provide one year of actual results and three years of projections of <u>Total Facility</u> revenue, expense and volume statistics without, incremental to and with the CON proposal in the following reporting format:

Total Facility: Description	FY Actual Results	FY Projected W/out CON	FY Projected Incremental	FY Projected With CON	FY Projected Wout CON	FY Projected Incremental	FY Projected With CON	FY Projected Wout CON	FY Projected Incremental	FY Projected With CON
Govt, Gross Revenue	↔	↔	€9	69-	€9		\$	₩		6
non-Govt. Gross Revenue Total Gross Patient Revenue	₩	\$	69	69	\$	\$	\$	69	€9	
Less; Uncompensated Care	↔	€9-	↔	↔	↔	↔	₩	₩	€9	4A
Total Net Patient Revenue	₩	€	€9	\$	₩	\$	9	€9	69	
Plus; Other Operating Revenue Revenue from Operations	\$	₩	€	€9	₩	€9-	€9	₩	€9	44
Salaries and Fringe Benefits Professional Services Supplies and Drugs Lease Expense	↔	↔	↔	₩.	↔	↔	()	↔	∨	(Δ
Depreciation/Amortization Interest Expense Other Operating Expense										
Total Operating Expense	6	↔	∽	↔	↔	₩	vs	⇔	€	40
Gain/(Loss), from Operations	₩	₩	\$	€	€	€	€9	€>	s	₩
Plus; Non-Operating Revenue Revenue, Over/(Under). Expense	₩	₩.	₩	₩	₩	ts.	ı,	6	₩	
Number of Entl Time										

Number of Full Time Equivalent Employees:

"Volume Statistics:

*Provide projected inpatient and/or outpatient statistics for any new services and provide actual and projected inpatient and/or outpatient statistics for any existing services which will change due to the proposal.